



**MARYLAND HEALTH CARE COMMISSION**

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215  
TELEPHONE: 410-764-3460 FAX: 410-358-1236

March 25, 2020

**VIA Email & U.S. MAIL**

Catherine Briggs, Vice President of Operations  
Pyramid Healthcare, Inc.  
P.O Box 967  
Duncansville, PA 16635

**Re: Pyramid-Walden, LLC – Joppa ICF facility  
Matter No. 20-12-2440**

Dear Ms. Briggs:

Commission staff has reviewed the application and first completeness responses from the Pyramid Walden, LLC for Certificate of Need (CON) approval to establish a 50-bed Track One Level III.7 medically monitored intensive inpatient treatment program in Joppa, Harford County. The total project cost is estimated to be \$5,194,069. There are areas in the original application and responses that were found by staff to be incomplete, and, therefore staff requests that you provide responses to the following questions:

**Sliding Fee Scale**

1. What documentation do you require to determine a patient's income level?

**Project Budget (Table B)**

2. "Working Capital Startup Costs" are estimated to be \$200,000. What costs are included in this category?

**Statistical Projections (Tables F,G)**

3. In response to the first set of completeness questions, food costs for patients were projected to be \$20 per day at the Joppa facility. Where in the revenue and expense budget is this cost reflected? If not subsumed under a broader cost category, please submit a revised table including costs for food and any other contractual arrangements that have been made for the implementation of the project.

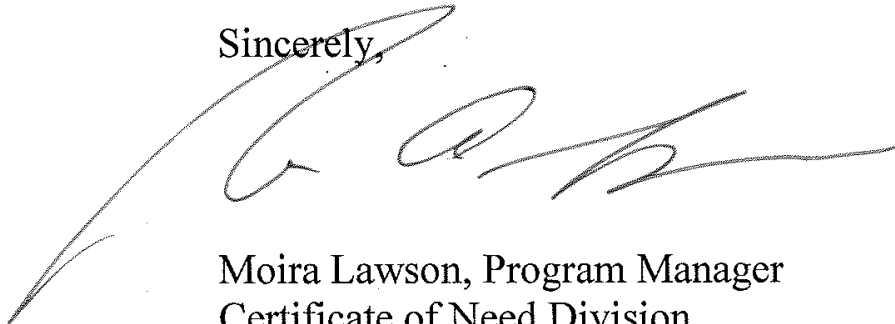
4. Salary projections provided on Table F do not match those on Table G. Please explain the discrepancies and/or replace the table(s) with corrected versions.

Please submit four copies of the responses to above questions and requests for additional information within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov ). If additional time is needed to prepare a response, please let me know at your earliest convenience.

As with the request itself, all information supplementing the request must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, please leave a message at (410) 764-3232 or you can call me on my cell phone at (203) 715-3307.

Sincerely,

A handwritten signature in black ink, appearing to read 'Moira Lawson', is written over a large, light-colored, stylized graphic that resembles a large, sweeping 'L' or a checkmark.

Moira Lawson, Program Manager  
Certificate of Need Division

cc: Jonathan Wolf, President Pyramid Healthcare Inc.  
Kevin McDonald  
Russel Moy, Health Officer, Harford County Health Department